## Michigan Department of Community Health Bureau of Health Professions P.O. Box 30192 Lansing, MI 48909 (517) 335-0918

www.michigan.gov/healthlicense

## **BOARD OF VETERINARY MEDICINE - CLINICAL ACADEMIC LIMITED** CERTIFICATION OF APPOINTMENT TO AN ACADEMIC POSITION

Authority: Public Act 368 of 1978, as amended If this form is not completed, a license will not be issued.

## YOUR LICENSE WILL NOT BE RENEWED UNTIL WE RECEIVE THIS INFORMATION REGARDLESS OF THE PAYMENT METHOD YOU USE

INSTRUCTIONS: Please type or print on this form. The Director of Medical Education must sign either

| Section A or Section B as appropriate          | <b>)</b> .        |                         |            |                                  |  |
|--|-------------------|-------------------------|------------|----------------------------------|--|
| Section A: Clinical Academic Lim               | ited Renewal -    | NO CHANG                | ES         |                                  |  |
| I am continuing my academic a current license. | appointment in th | ne same prog            | ram at     | the same location as shown on my |  |
| First Name:                                    | Middle Name:      |                         | Last Name: |                                  |  |
|  |                   | T                       |            |                                  |  |
| Michigan Permanent I.D./License Number:        |                   | Social Security Number: |            |                                  |  |
|  |                   |                         |            |                                  |  |
| [a   |                   |                         |            |                                  |  |
| Signature of Director of Medical Education:    |                   |                         |            | Date:                            |  |
|  |                   |                         |            |                                  |  |
| Section B: Clinical Academic Lim               | nited Renewal -   | WITH CHAI               | NGES       |                                  |  |
| I am continuing my academic shown below.       | appointment b     | ut will transfe         | er to a    | new hospital and/or program as   |  |
| irst Name: Middle Name:                        |                   | Last N                  |            | Name:                            |  |
|  |                   | Zastriams               |            |                                  |  |
| Michigan Permanent I.D./License Number:        |                   | Social Security Number: |            |                                  |  |
|  |                   |                         |            |                                  |  |
| Hospital Name:                                 |                   |                         |            |                                  |  |
|  |                   |                         |            |                                  |  |
| Program Name:                                  |                   |                         |            |                                  |  |
| Hospital Street Address:                       |                   |                         |            |                                  |  |
| Trospital Street Address.                      |                   |                         |            |                                  |  |
| City:  |                   | State:                  |            | Zip Code:                        |  |
| Oity.  | Sta               | ie.                     |            | Soue.                            |  |
|  |                   |                         |            |                                  |  |
| Signature of Director of Medical Education     |                   | Date:                   |            |                                  |  |
| Tolginature of Director of Medical Education   |                   | Date.                   |            |                                  |  |

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